



What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY
HEALTH AND FAMILY PLANNING PROJECT



Vol. 2, No. 13, April 2002

Navrongo Health Research Centre

CHIPPING CHPS TO SIZE

What works?... recently sat down with Dr. Alex Korshie Nazzar, former PI of the CHFP and now at the Health Strategy Development Unit of the Ghana Health Service.

WW: *You have been directly in charge of the Community Health and Family Planning (CHFP) Experiment before, what were the problems with the scale-up and how did you manage them?*

KN: The problems of the scale-up of the lessons from the CHFP had to do with understanding the import and policy implications of the findings from Navrongo.

WW: *What is your understanding of the Community-Based Health Planning and Services (CHPS) initiative?*

KN: CHPS is a strategy to deliver PHC services based on the conviction that communities cannot and should not continue to be passive recipients of health technology but must be active players in the full process. What people seem to be doing currently regarding CHPS is putting a nurse in the community and saying they are implementing CHPS. The concept is about extending health care planning and service delivery into the community with the community itself mobilized to accept and utilize the services. The nurse is sent to the community to perform three main functions: (1) "Reconnaissance Agent" who goes to the community to better understand the community needs, and to communicate these needs to the sub-District to enable the DHMT to plan a more effective and relevant service delivery intervention; (2) "Technical Assistance" provider for better home management of common ailments through health education activities, and (3) "Change Agent" to facilitate the adoption of better health-seeking behaviour.



Dr. Korshie Nazzar feeling the impact of improved health coverage on child survival

WW: *What's the best approach to CHPS implementation?*

KN: The first step in getting this going is building understanding in the community. First of all you must understand that you are going to make a major change in the pattern of service delivery. Usually when you talk about health in a community, members immediately tend to think and talk about the availability or otherwise of a fixed-facility Health Centre or a Hospital, because that is the paradigm they have always known. But that is exactly the paradigm you want to change. You would discuss with them that you are talking about health but you are not talking about a fixed facility. If you don't go through that process thoroughly to get the community to understand and accept this new concept of health care delivery they will be dissatisfied with the nurse when she eventually comes to live in the community.

WW: *Are you talking about a mobile clinic of sorts?*

KN: No. We are talking about preventive health. The primary purpose of the nurse going to the community is the provision of health education for disease prevention and health promotion. Her presence in the community and her consequential knowledge of the health conditions of the community will assist the sub-districts in identifying the problems that the sub-District Team Managers will plan to address adequately. The concept is not to put a nurse there to "solve" the community's problems. The nurse cannot do it—no nurse can, without the support of the sub-District team and the community; do what is currently being conceptualized as the role of the nurse in the community. No nurse can go to the community and single-handedly do deliveries, treat malaria, treat diarrhoea, carry out immunizations and so on. It cannot work. We were conscious of the fact that once the tag 'nurse' is put on the community health service provider, it would raise expectations of clinical services. But in actuality her main training had been in preventive health care. So it was decided that while in the community providing health education, the Community Health Nurse should be redesignated as Community Health Officer and equipped to provide basic treatment for minor ailments—but this was never to be her main preoccupation in the community. She was never to replace the Health Centre. In fact the Health Centre is still the backbone to the CHPS strategy.

WW: *Is that the reason why CHPS is running into problems?*

KN: There are many reasons why CHPS is running into problems.

WW: Community based... Health Planning...

KN: ...and Services. People distinctly hear “service”; they don’t hear “planning” so clearly and even if they do the real import is lost on many. They equate “service” to clinical activity.

WW: A typical community does not have complex health problems. In Kassena-Nankana district, if a nurse is trained to do deliveries and treat malaria much of the health burden is taken off.

KN: That is where the concept of CHPS has been misconstrued. CHPS is a service delivery strategy beginning at the periphery. Once you improve service delivery at the periphery the services at the sub-district have to be improved too. The structures around to which the nurse can refer cases must also be improved. There must be efficient communication and regular supervision. Here I am talking about effective facilitatory supervision where you go to find out what difficulties the nurse is facing—to see if the health delivery strategy of the sub-district is on course and to offer assistance to make this happen. As a “Reconnaissance Officer” in the community she is best placed to let the sub-district know how well-targeted their plans and interventions are.

WW: What is the difference between CHFP and CHPS?

KN: CHFP tried to find out which ones of many strategy options work. CHFP tried to see what happens when you involve communities in health planning and service delivery. CHFP dialogued between health professionals, political leadership, and traditional leadership to look at options to widen access to and raise the quality and efficiency of health care delivery. That is why the experiment looked at various options and combinations thereof. In Cell I only volunteers were put in a mobilized community. Cell II had only the health worker without mobilizing the community and in Cell III we combined the strategies in Cells I and II. Cell IV was the control where no intervention took place. In short, CHFP is an experiment whose results uncovered new ways of doing things. CHPS is an innovation that took the CHFP findings and fashioned out a strategy for delivering health service outside experimental conditions.

WW: What does it take to move from CHFP to CHPS?

KN: You need to develop counterpart technologies, which were relevant lessons learnt from the CHFP experiment that needed to be pointed out and developed further. There was a strong level of community dialogue, dialogue with the nurse, supervision, education, motivation and many others. All these were under experimental conditions. Some failed, some performed poorly, and others excelled. The lessons from these were looked at and formulated into a feasible strategy and improved upon for delivery within a nonexperimental arena. This ensemble of strategies constitute CHPS.

WW: Have we really got it wrong?

KN: Yes we have. It’s like you make a car. The beauty of the car attracts people and they buy it. They take it away and try it. It starts and moves a little distance then it stops. And the conclusion is that the car is not good.

WW: The customer does not have the manual!

KN: He hasn’t taken time to study the manual. When we went outside of Navrongo and started disseminating findings of the CHFP, concerns were raised that this thing could only work in Navrongo. We emphasized that what mattered from the experimental findings was the concept of community dialogue and process of community consultations and not the particular style of community organization that was used in Navrongo.

WW: Could it be that Navrongo is not disseminating properly?

KN: No, no. This thing was talked through carefully. Communities have a lot of resources in terms of suggestions, capabilities and abilities that can be mobilized using our professional skills. This is the fact Navrongo is disseminating. When it came to scale up, we looked back and honestly realized that we didn’t arrive at the end product without problems and that was communicated clearly. Dialogue with the communities is indispensable to the success of CHPS but that is exactly what people are sidestepping.

WW: How do you see Navrongo pulling all these loose ends together?

KN: I don’t want to sound presumptuous. But put your ears to the ground. If you look at what is happening to the CHPS scaling-up process, there are lots of issues for clarification, investigation and further research.



Dialogue with the community is central to community-based health service operations

Send questions or comments to: What works? What fails?

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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, are hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation.